SARS and Tuberculosis

The old and the new: still with us and doing well

by Robert Howard

On September 23 and 30, 2003 the Centers for Disease Control and Prevention hosted a televised "webcast" program intended for health care workers, immigration officials, physicians and researchers entitled "Preparing for the Return of SARS – Are we Ready?"

Wait a minute. Wasn't this the same disease that just four months ago the outgoing Director of the World Health Organization (WHO) declared, "dead" and "stopped in its tracks?" Well, it seems SARS (Sudden Acute Respiratory Syndrome) is not dead, and, as is evidenced in the media coverage both here in the U.S. and abroad, SARS has already begun its comeback with "SARS-like" illness being reported in the U.S., Canada and other countries. In many cases in rural or remote areas there isn't the laboratory capability to assess tissue samples and determine the exact nature of a SARS suspected death, and the person is simply buried without a thorough evaluation and determination of the cause of death. Instead a vague "acute respiratory distress syndrome" label is attached and the case forgotten.

While the CDC will make a valiant effort to inform and collaborate with the WHO and its counterparts abroad, there is little doubt SARS will continue to challenge the health of Americans, especially those who are most at risk – the elderly, immune-compromised, asthmatics, and persons with other serious underlying health problems.

At present the CDC has eight Quarantine Stations located in Atlanta, Miami, Chicago, New York, Honolulu, Seattle, San Francisco and Los Angeles. There are approximately 320 airports in the U.S. at which SARS infected patients could enter the country. The math is quite simple: we have over three hundred airports in the U.S. in which no one has the capability or capacity to evaluate visitors, passengers or immigrants for SARS, TB, plague, typhoid or Yellow Fever or the host of other illnesses that have appeared in the last year in nations where we travel to visit, or have immigrants coming to us.

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Let it be known that SARS should serve as a warning to all medical and elected leaders in the world of the power of these microbial threats. Even when knocked down and thought to be out for the count, most of these pathogens have an uncanny ability to regroup and resurface. The U.S. public health community relies on the strength, outreach, ability and integrity of other nations to report disease outbreaks, and bring to bear the full weight of a number of global health agencies to assist in evaluating and eliminating the threat. All too often countries are reluctant to admit to these outbreaks for fear of loss of trade and tourism. China continues to be difficult to deal with in the SARS arena and hesitant to allow outsiders in to evaluate and help. Just two weeks ago, in the very province where SARS began, the Chinese continued to move forward with plans for the largest airport in the country. And at ground zero of the

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initial outbreak they took weeks to create and display for global media consumption, the world's largest human domino chain – when the final participants fell it triggered a fireworks display. If only that much work and effort had gone into the initial SARS outbreak when it was common knowledge that the Chinese were hiding patients and health care workers infected with the illness in local hotels and homes. The domino effect has an easy parallel to the death of hundreds of Chinese who died without the benefit of a rocket show as their government obfuscated and denied the truth. The Chinese appear to prefer flash and sound-bites over the illness and death of their own citizens and visitors from abroad.

So here in the U.S., the CDC and other healthcare institutions will do yet another round of education for health care professionals and hope to be prepared for the re-emergence of SARS which is widely and globally predicted to come back. The stated purpose of this medical outreach by the CDC is to "Describe key strategies for implementing healthcare preparedness and planning to contain the spread of SARS and to define the means for early detection of SARS in local communities." In other words, SARS will be back, and you should hope your community will be prepared.

TB: The Killer That Never Quits

The Health Resources and Services Administration's Division of Immigration Health Services reports approximately 150 TB cases are identified annually among INS detainees in processing centers before deportation. This figure does not in any way reflect the number of illegal immigrants who cross the border, settle in communities around the nation and carry tuberculosis into homes and workplaces. Before deportation or transfer, INS regulations require that these detainees receive treatment until they become non-contagious, even if treatment is not completed. This, of course, can lead to a drug resistant form of TB when the detainee is returned to his or her country and perhaps attempts to enter the U.S. again.

In three recent cases cited in May, 2003, the CDC described in the "Morbidity and Mortality Weekly Report" the underlying problem of tracking and maintaining any sort of constant and coordinated therapy course on infected illegal immigrants and admitted it is nearly impossible under current U.S. laws and INS procedures to manage these persons effectively. It is not unusual, as was the case in all three instances cited by the CDC, to have detainees begin therapy, be deported, and return in a short time with a drug resistant form of the illness. Of course, the illegal immigrant is arrested yet again, begins drug therapy at a cost to American taxpayers that is now ten times greater than the original course of treatment, and once again, is returned to the country of origin.

During these "visits" to the U.S., these infected persons can be incarcerated or, more commonly, interact with American citizens in mass transit, work environments, shopping areas, and public events. They are highly contagious and a genuine threat to the well-being of healthy citizens when they cough or sneeze while preparing food, working in landscaping, or laboring in home building, all the while living among disease-free Americans.

The government, through the INS, has requested an expansion of the "hold" authority for ill**e**gal immigrants until they have completed the full course of TB treatment (which can take up to six months) with daily observed treatment. To date, the Office of Homeland Security, which now has assumed the direction and functions of the Directorate of Border and Transportation Security, Bureau of Immigration and Customs Enforcement, has taken no action to secure this issue with Congress or in state legislatures.

As if there needed to be more evidence for action on this issue, data collected for fiscal years 2001-2002 indicates that while there were 24,361 cases of TB in 1994 (a 20 percent rise after a thirty-year decline), there has been a continued increase in TB cases that are multi-drug resistant. TB is treatable and preventable. This is a reminder of the importance of sound national and international public health system communications and surveillance. It underscores the vital nature of honesty in reporting, follow-up, and tracking by host nations and a reliance on the honesty of health care officials abroad who all too often fail to meet the oath, "Physician do no harm," as well as on the integrity of politicians and leaders who frequently fail in their oath to "serve to protect the borders against *all* enemies, foreign and domestic." •